TEXAS DEPARTMENT OF HEALTH QUALITY ASSURANCE
TARGETED CASE MANAGEMENT FOR HIGH RISK PREGNANT WOMEN AND HIGH RISK INFANTS (PWI)
AND
TEXAS HEALTH STEPS MEDICAL CASE MANAGEMENT (MCM)
Instructions for QA reviews

- * indicates those items for which 100% compliance required to receive a "yes" answer. All other items have an 80% compliance requirement to receive a "yes" answer. Items falling outside of the tolerance will receive a "no" answer.
- Items not reviewed should receive an "N/R."
- Any item marked "no," "N/A" or "N/R" on any tool, must be explained in comments section of that tool. Mark section letter and item number on comments section and note reason for "no" or "N/A"—if on site review tool, just make notes in comments section adjacent to that item.

REVIEW CRITERIA	Instructions
I. Case Management Provider Administrative Review	
A. Case Manager Credentials	
Case managers meet rule requirements for licensure, education and experience as evidenced by examination of employee personnel files.	
1. Licensure.*	Review provider personnel records for current licensure. Must be RN or social worker license. Record findings on Case Management Personnel Review Tool in the licensing column. All case managers, current and former (for the past two years) should be reviewed. All case managers must meet this requirement or "No" is marked on site review tool.

REVIEW CRITERIA	Instructions
2. Proof of required experience.*	Review provider personnel records for resume or application that describes case management experience. Record findings on Case Management Personnel Review Tool in the experience column. All case managers, current and former should be reviewed. All case managers must meet this requirement or "No" is marked on site review tool. To determine years experience use the TDH instructions for job application screening--- · Only consider what is stated on the resume, application and attachments. · Time periods of experience from several jobs can be combined to determine total experience credit. · Part-time experience can be accepted, but must be converted to a full-time equivalent. Use the following formula: number of hours worked per week **x** the number of months worked divided by 40 hours per week = the number of months of full-time experience Example: 20 hours/week **x** 12 months = 240 hours. 240 hours/40 hours = 6 months full-time experience · If only month and year are listed (i.e., 1/95 - 12/95), drop the first and last months and only give credit for the experience in between. In this example, the total credit would be 10 months. · If only years are listed (i.e., 1993 - 1995), drop the first and last years and only give credit for the experience in between. In this example, the total credit would be one year. · Periods of full-time experience with overlapping dates can be considered, but must be clarified. · If the date for the most recent job is listed as "current," "present," or left blank with "No" reason for leaving position, experience is counted up to the date of the signature on the application or the date on the resume.
3. (MCM) Proof of education.*	All MCM case managers must have, at a minimum, a bachelor's degree. Record type of degree on Case Management Personnel Review Tool in the degree column. All case managers, current and former should be reviewed. All case managers must meet this requirement or "No" is marked on site review tool. PWI rules do not require a degree—if provider is PWI only, mark N/A on record review tool.

REVIEW CRITERIA	Instructions
4. Certificate of Attendance for TDH required training dated after January 1, 2002.*	All case managers must have attended training since January 1, 2002. Record date of most recent training on Case Management Personnel Review Tool in the TDH Training column. All case managers, current and former should be reviewed. All case managers must meet this requirement or "No" is marked on site review tool.
B. Policies and Procedures	
1. Case management rules, policies and procedures are kept current and are accessible to staff, as evidenced by:	
a. Direct review of TDH case management reference manual.	Observe whether all case management staff has access to a reference manual.
b. Direct review of internal agency policies.	Observe whether all case management staff has access to the provider's internal policies.
c. Stored in location accessible to all case management staff.	Both internal policies and the reference manual must be accessible for all staff, even staff providing services out of their homes.
2. Case management provider has documented organizational structure as evidenced by examination of:	
a. A current organizational chart that shows the lines of authority and supervision.	Review the organizational chart. The chart must show lines of authority and supervision.
b. Documented functional job descriptions for case managers and QA staff that include required qualifications, appropriate levels of training/education, credentials and experience.	Review the job descriptions for case managers and QA staff. Job descriptions must include: required qualifications, appropriate levels of training/education, credentials and experience required and job responsibilities.

REVIEW CRITERIA	Instructions
3. Case management provider has appropriately addressed client confidentiality and storage of original and photocopied client records that are maintained by individual case managers as evidenced by examination of internal policy to include:	
a. Storage in a locked location.	Policy must address the locked location in which records will be stored.
b. Confidentiality during transportation of client records.	Policy must spell out what steps will be taken to ensure the security of the records while being transported.
c. Disposal of duplicate client records.*	If the provider does not make duplicate records---mark "N/A" on the site review tool. If the provider has a policy that appropriately addresses the disposal of duplicate records mark "Yes" in the site review tool.
4. Case management provider follows their internal policy for storing records in a locked location.*	Observe location in which records are stored. The records must be stored according to the provider's internal policy. If records are stored in location with lock, mark "Yes" on the site review tool. If records are not stored in a locked location, mark "No" on the review tool.
5. The agency will ensure that staff abides with Chapter 261 and Rider 14	
a. The agency/provider has adopted the TDH Child Abuse Screening, Documenting and Reporting Policy into the agency's/provider's internal policies.*	Review agency/provider policy manual to insure it includes the TDH Child Abuse Screening, Documenting, and Reporting Policy as written or a statement which adopts the policy as written. If the provider has not adopted the policy mark "No" on the review tool.

REVIEW CRITERIA	Instructions
b. The agency/provider has an internal policy and procedure for how it will determine, document and report instances of abuse, sexual or non-sexual, in accordance with the Texas Family Code, Chapter 261.*	Examine the agency/provider's internal policy which details how the agency/provider will determine, document and report instances of abuse, sexual or non-sexual for all unmarried clients under the age of 17 in compliance with the Texas Family Code, Chapter 261. The policy should address: ?? How the agency determines whether an unmarried client, under the age of 17, has been abused or neglected as defined by the Family Code §261.001, including but not limited to, victims of an offense under the Penal Code §21.11, §22.011, or §22.021; ?? That, for all unmarried clients under the age of 17 who have been determined to have been abused or neglected as defined by the Family Code §261.001, including but not limited to, victims of an offense under the Penal Code §21.11, §22.011, or §22.021, a report to the appropriate authority is required unless an affirmative defense is documented and the policy addresses the time frames for reporting. A professional must report within 48 hours of a determination. A non-professional must report immediately. o An affirmative defense for abuse as defined in the Penal Code §21.11 may be: 1) the actor was not more than three years older than the victim and of the opposite sex; and 2) the actor did not use duress, force, or a threat against the victim at the time of the offense. o An affirmative defense for abuse as defined in the Penal Code §22.011 may be: 1) the actor was not more than three years older than the victim at the time of the offense. o There is no affirmative defense applicable for abuse of children under the age of 14 because a child under 14 cannot consent to sexual activity under Texas law. ?? How the contractor will document the above determination, affirmative defense or report. At a minimum, the policy must clearly state that staff must include a statement in the client's file or the centralized tracking system that either 1) a report was not required and the basis for that determination or 2) a report was required .The policy may direct the staff to document additional information if the contractor wishes to do so. If the agency/provider policy does not address all of these items, mark "No" on the review tool.

REVIEW CRITERIA	Instructions
c. The agency/provider appropriately documented and reported, according to the TDH Child Abuse Screening, Documenting and Reporting Policy, all clients who are unmarried minors under 14 years of age who are pregnant or have a confirmed sexually transmitted disease acquired in a manner other than through perinatal transmission.*	Ask the agency/provider for the records of all clients under 14 years of age who are pregnant or have a confirmed sexually transmitted disease acquired in a manner other than through perinatal transmission. Each record should include the Checklist for TDH Monitoring and documentation that a report was made. A professional must report within 48 hours of a determination. A non-professional must report immediately; i.e., no later than the same date the determination was made. If a record for a client who does not meet the above criteria is provided to the reviewer, the record should be reviewed to insure that the contractor's internal policy has been followed for determining, documenting and reporting instances of abuse. If it is determined that a report was not documented when one should have been made, the agency/provider will be directed to make a report before the end of the business day. If any one record doesn't include the checklist mark "No." All clients reviewed that meet criteria should be listed on the Chapter 261 Record Review Tool. If the provider doesn't have any clients under age 14 who are Pregnant or have a confirmed sexually transmitted disease this section will be "N/A."
6. Case management provider has documentation of required staff inservices on:	
a. Home visitation/safety issues.	Review sign-in sheets or other documentation indicating all staff has attended training on home visitation/safety issues. Indicate on personnel review tool who attended training. If at least 80% attended, mark "Yes" on site review tool, if less than 80% mark "No."
b. Policies and procedures for reporting abuse.*	Review sign in sheets or other documentation indicating all staff have attended training on the TDH Child Abuse Screening, Documenting and Reporting Policy and the agency/provider's internal policy for determining, documenting and reporting instances of abuse. Indicate on personnel review tool who attended training. If all attended, mark "Yes" on site review tool. If one or more case managers did not attend the training mark "No" on the review tool.

REVIEW CRITERIA	Instructions
7. Case management provider maintains a directory of appropriate referral sources that includes names, addresses, phone numbers and a brief description of services provided as evidenced by:	
a. Examination of resource directory.	Review resource directory for appropriate resources for the service area. If the resources appear to be appropriate, mark "Yes" if they are not appropriate, mark "No."
b. Accessibility of directory to all staff.	Observe location of directory. Is it in a location that is accessible to all staff, or is it in someone's office? Ask how it is accessible to case managers working out of their homes.
c. Examination of the case management provider's policy for updating the directory.	Review provider's policy for updating the resource directory. Does it include steps for update on at least an annual basis? Does it include resources that will be used to update the directory? Does it include steps to add a new resource or remove a resource that is no longer available? If yes to all then mark "Yes" on site review tool otherwise mark "No" on the review tool.
d. Evidence that resource directory is updated at a minimum of once a year.	Review directory for dates that the directory was updated. If no evidence that directory was updated in the past year, mark "No" on site review tool.
8. Civil Rights Act	
a. The agency has written non-discrimination policies and procedures established for compliance with civil rights statutes, regulations, and TDH policies.	The agency must have written non-discrimination policies and procedures established for compliance with TDH policies on non-discrimination in employment, programs, and services, and with all applicable civil rights statutes, including but not limited to: Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Title IX of the Educational Amendments, and the Age Discrimination Act of 1975. If the agency has written non-discrimination policies and procedures in place, mark "Yes" to this question, obtain 2 copies of the policies and procedures from the agency, and forward to Ebe. She will send one copy to the Office of the Ombudsman (OTO) the other will be placed in the agency's file.

REVIEW CRITERIA	Instructions
b. The agency has completed the *Self-Evaluation Checklist for Non-Discrimination Policies and Procedures*.	If the agency has completed the checklist, mark "Yes" to this question, obtain 2 copies of the checklist from the agency, and forward to Ebe. She will send one copy to the Office of the Ombudsman (OTO) the other will be placed in the agency's file.
c. There were no observed violations of required non-discrimination policies and procedures during the on-site visit.	Record any observations made during the on-site visit regarding the agency's non-discrimination policies, procedures, and practices in the Comments section of the review tool. These may be positive or negative observations regarding the actual application or interpretation of the agency's non-discrimination policies or procedures by agency staff during the on-site visit. **Positive Example:** The agency includes a statement regarding its non-discrimination policies and procedures in all of its application and educational materials, and translates these materials in to non-English languages frequently encountered in the service delivery area. **Negative Example:** The agency has failed to post the appropriate notice of non-discrimination posters in a location visible to all employees, applicants and clients.
9. Limited English Proficiency	
a. The agency has written policies and procedures established to address the needs of clients with limited English proficiency (LEP) as required by Title VI of the Civil Rights Act of 1964.	The agency must have written policies and procedures to address the needs of clients with Limited English Proficiency (LEP), as required by Title VI of the Civil Rights Act of 1964. If the agency has written policies and procedures in place for serving LEP clients, mark "Yes" to this question, obtain 2 copies of the policies and procedures from the agency, and forward to Ebe. She will send one copy to the Office of the Ombudsman (OTO) the other will be placed in the agency's file.
b. The agency has completed the *Self-Evaluation Checklist for Limited English Proficiency (LEP) Policies and Procedures.*	The agency must conduct a self-evaluation of its policies and procedures for serving Limited English Proficiency clients using the attached ***Self-Evaluation Checklist for Limited English Proficiency (LEP) Policies and Procedures.*** If the agency has completed the LEP checklist, mark "Yes" to this question, obtain 2 copies of the checklist from the agency, and forward to Ebe. She will send one copy to the Office of the Ombudsman (OTO) the other will be placed in the agency's file.

REVIEW CRITERIA	Instructions
c. There were no observed violations of required LEP policies and procedures during the on-site visit.	Record any observations made during the on-site visit regarding the agency's LEP policies, procedures, and practices in the Comments section of the review tool. These may be positive or negative observations regarding the actual application or interpretation of the agency's non-discrimination policies or procedures by agency staff during the on-site visit. **Positive Example:** Agency staff informs LEP clients of their right to interpreter services free of charge, and records the name and affiliation of the interpreter(s) used in the client's record at each visit. **Negative Example:** Agency staff fails to inform an LEP client of their right to free interpreter services, and instead rely on the client's 10-year-old child to interpret for the client.
10. Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act	
a. The agency has written policies and procedures established for compliance with the non-discrimination and accessibility provisions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, as amended.	The agency must have written policies and procedures established for compliance with the non-discrimination and accessibility provisions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, as amended. If the agency has written policies and procedures in place for ADA/Section 504 compliance, mark "Yes" to this question, obtain 2 copies of the policies and procedures from the agency, and forward to Ebe. She will send one copy to the Office of the Ombudsman (OTO) the other will be placed in the agency's file.
b. The agency has completed *The Self-Evaluation Checklist for ADA/Section 504 Policies and Procedures* and the *ADA Checklist for Readily Achievable Barrier Removal.*	The agency must conduct a self-evaluation of its policies and procedures for ADA/Section 504 compliance using the attached ***Self-Evaluation Checklist for ADA/Section 504 Policies and Procedures.*** If the agency has completed the checklist, mark "Yes" to this question, obtain 2 copies of the checklist from the agency, and forward to Ebe. She will send one copy to the Office of the Ombudsman (OTO) the other will be placed in the agency's file.

REVIEW CRITERIA	Instructions
c. There were no observed violations of required policies, procedures and practices for ADA/Section 504 during the on-site visit.	Record any observations made during the on-site visit regarding the agency's ADA/Section 504 policies, procedures, and practices in the Comments section of the review tool. These may be positive or negative observations regarding the actual application or interpretation of the agency's non-discrimination policies or procedures by agency staff during the on-site visit. **Positive Example:** Agency staff informs hearing-impaired clients of their right to sign language interpreter services free of charge and ensure that arrangements are made in advance for such an interpreter to avoid a delay in service to the client. **Negative Example:** Agency staff informs hearing-impaired clients that they must provide their own sign language interpreter services and that the agency charges a fee to provide this service for the client.
11. Corrective Actions for Self-Evaluation Checklist	
a. The agency has identified problems in completing the three (3) self-evaluation checklists.	Observe that the provider has documented any problems identified when completing the checklist.
b. The agency has completed corrective actions to address problem areas identified by the three (3) self-evaluation checklists.	Observe that the provider has documented evidence of completion of corrective actions to address any problem areas identified while completing the checklist.
c. If no corrective action has been taken to address problem areas identified by the three (3) self-evaluation checklists, the agency has developed proposed solutions and projected dates of completion for addressing the problems identified.	If the provider has not already completed and documented the corrective action taken to address any problem areas from the checklist, observe the provider's documented proposal for addressing the problem areas, including solutions and projected dates. If the provider has completed a corrective action, this item should be marked "Yes."
12. The agency has a written plan that includes safety inspections, fire drills, emergency evacuation procedures and inspections of fire extinguishers.	The agency has a written and implemented plan that identifies safety inspections, fire drills, emergency evacuation procedures and inspection of fire extinguishers. The plan should identify the frequency of these activities and there should be documentation to support that these inspections or activities are being performed. **This is not applicable to contractors who do not provide services on-site.**

REVIEW CRITERIA	Instructions
C. Communication and Coordination	
1. Case management provider adheres to policies regarding community communication and coordination as evidenced by:	
a. Examination of coalition meeting minutes and/or sign-in sheets documenting case manager attendance as required in policy.*	Observe coalition meeting minutes or sign-in sheets for coalition attendance. Each case manager must attend a minimum of two coalition meetings per year in the TDH Region for which they provide services. If all case managers have attended according to requirements the provider will receive a "Yes." If some but not all of the case managers have attended, the provider should receive a "No."
b. Review of significant provider change forms documenting provider changes as required in policy.*	Providers must submit written notice of significant changes (case management supervisory personnel, case management staff, service area, active or inactive status, not accepting new referrals, change of address, telephone number, fax number, email address or change of ownership) within five working days of occurrence. Review all significant change forms and determine that all changes have been documented on a change form and sent to TDH. If all changes have been documented, the provider should receive a "Yes." If not, the provider should receive a "No." If no significant provider changes have occurred, the provider should receive a "N/A."
c. Examination of minutes, documentation or photographs to reflect appropriate outreach/education.	Review any documentation of outreach/education activities which may include: educating potential clients through health fairs, awareness campaigns, Public Service Announcements, brochures, communication with physicians etc. Assure all provider created outreach materials were approved by TDH prior to use. If agency did appropriate outreach/education and had materials approved mark "Yes." If agency did not, mark "No."

REVIEW CRITERIA	Instructions
D. Quality Assurance	
1. Case management provider has a documented quality assurance plan/policy that:	
a. Integrates case management services into the provider's overall QA Plan, when appropriate.*	Review the provider's QA Plan. Case management programs in agencies, which receive additional TDH funding, must assure that QA activities for case management are integrated into the provider's overall QA Plan. If activities for case management are included in the overall plan, the provider should receive a "Yes." If not, the provider should receive a "No." If agency does not receive additional funding, or does not provide other services, mark "N/A."
b. Includes areas to be reviewed: Administrative, Service Delivery and Billing.*	Review the provider's QA Plan. All the following areas must be included in the plan: 1. Administrative * Updated provider personnel, records and internal policies * Current job descriptions, licensure and * Current organizational chart 2. Service Delivery * Annual observation of client/staff interactions * Record reviews 3. Billing * Review of Remittance and Status reports * Verification with client records If all areas are included in the QA Plan, the provider should receive a "Yes." If not, the provider should receive a "No."

REVIEW CRITERIA	Instructions
c. Describes the frequency and number of record reviews, billing reviews and observation of case manager/client interactions.*	Review the provider's QA Plan. The plan should include time frames for reviews. The provider should consider 10% record and billing review quarterly or a sample large enough to identify problem areas. Observations should be conducted at least annually. If the QA Plan includes time frames, the provider should be given a "Yes." If not, the provider should receive a "No."
d. Includes use of TDH tools for record and billing review and observation of services.*	Review the tools the provider is using for billing and record reviews and observation of services. If the provider is not using the TDH tools, the provider should receive a "No."
e. Defines qualification of staff performing internal QA activities.*	Review the provider's QA Plan/Policy. The plan/policy should define who will conduct QA activities. A qualified case manager who has attended the TDH training must conduct record review and case management observations. Eligible case managers may perform peer review of records and observe each other's service delivery. If any of the staff performing record and/or billing reviews does not meet the criteria, the provider should receive a "No."
f. Indicates process for completion of satisfaction surveys in accordance with TDH policy.*	Review the provider's QA Plan or Policy. The plan/policy should include the procedures for conducting satisfaction surveys. Providers will use form number CPW-10 to survey all clients. THSteps MCM providers will use CPW-11, and CPW-12, respectively, to survey all PCPs and case managers. Survey responses must be maintained as a component of the internal Quality Assurance process and copies of the responses submitted to TDH Central Office annually (by January 31st for the previous calendar year) for program staff review. If the QA Plan/Policy does not contain information on the completion of satisfaction surveys, the provider should receive a "No."
g. Documents the process to identify corrective actions for QA results, which ensure findings from QA activities, receive follow-up.*	Review the provider's QA Plan/Policy. The provider internal QA Plan/Policy must clearly identify how and by whom any needed corrective actions, which are warranted as a result of the QA process and satisfaction survey results, will be implemented. The provider internal QA Plan/Policy must clearly identify how required staff development, as a result of internal QA findings, will be implemented. If the QA Plan does not contain information on the process to identify corrective actions, the provider should receive a "No."

REVIEW CRITERIA	Instructions
2. Case management provider has implemented QA activities as evidenced by:	
a. Completed record review tools.*	Review the completed record review tools. Assure tools were completed according to the provider's internal QA Plan timeline. If the provider has not completed all the record review tools according to the timeline in their internal QA Plan, the provider should receive a "No."
b. Completed billing review tools.*	Review the completed billing review tools. Assure tools were completed according to the provider's internal QA Plan timeline. If the provider has not completed all the billing review tools according to the timeline in their internal QA Plan, the provider should receive a "No."
c. Completed tools for observation of services. *	Review the completed observation tools. Assure tools were completed according to the provider's internal QA Plan timeline (at least annually). If the provider has not completed all the observation review tools according to the timeline in their internal QA Plan, the provider should receive a "No."
d. Completed satisfaction surveys.*	Review the completed satisfaction surveys. Assure all surveys were completed according to the provider's internal QA Plan timeline. If the provider has not completed all surveys according to the timeline in their internal QA Plan, the provider should receive a "No."
e. Documented corrective actions to address QA findings.*	Observe the provider's corrective action plan which addresses the concerns identified during internal QA activities. Providers must present documentation of occurrence and necessary follow-up when quality issues are identified. If the provider does not have a corrective action plan for all identified findings, the provider should receive a "No."

REVIEW CRITERIA	Instructions
II. Observation/Interview	**If provider has:** **1-5 case managers, 1 case manager will be observed** **6-15 case managers, 2 case managers will be observed** **16 or more case managers, 3 case mangers will be observed** **If a provider is both MCM and PWI and two case managers are observed, one observation should be MCM and one should be PWI. If three case managers are observed, one will be MCM and one will be PWI, the third can be either MCM or PWI.** **If a provider is active in more than one public health region, one case manager will be observed in each region**
A. Case Manager Observations	
Case management services are provided according to policies and procedures as evidenced by direct observation of case manager/client interactions.	**All observation tools will be tallied for the site review tool. If more than one case manager is observed and any no's are received for any * areas, the provider should receive a "no." All other areas the provider receives "yes" on the site review tool if 80% of response were positive on an item. The provider receives a "no" if less than 80% of responses were positive.**
1. The case manager demonstrates appropriate rapport by:	
a. Wearing nametag.	Case manager should wear a nametag that includes name and credentials.
b. Greeting client and introduce self and observing staff.	Case manager should introduce self and the observer.

REVIEW CRITERIA	Instructions
c. Maintaining confidentiality.*	Case manager should maintain confidentiality. If any services are not provided in a confidential manner the provider should receive a "No."
d. Explaining case management and provides client choice (when applicable).*	Case manager should explain case management services and tell client/family that they have a choice of case management providers in the community when initially meeting the client/family. If any services are not explained or choice not offered, the provider should receive a "No." If choice was already offered to the client in another component, this item should be marked "N/A."
2. The case manager demonstrates appropriate communication by:	
a. Communicating at client's level.	Case manager should communicate at a level in which the client can understand.
b. Addressing language and cultural issues (when applicable).*	Case manager should provide appropriate interpreter services if necessary and should address any cultural issues identified during provision of services. If this is not done with every applicable client, the provider should receive a "No." If no language or cultural issues are evident, this item should be marked "N/A."
c. Working with client to identify needs and address problem areas.*	Case manager should identify any areas of need with client/family and problem solve with the client/family to solve the need. If this is not done with every client, the provider should receive a "No."
d. Using open-ended questions.	Case manager should use open-ended questions with client/family.
e. Evaluating client's understanding of discussion items.	Case manager should assure that client/family understands discussion of all issues.

REVIEW CRITERIA	Instructions
f. Demonstrating ability to problem solve with client.	Case manager should problem solve with client/family to address need areas.
3. The case manager provided appropriate referrals by:	
a. Giving choice of referral sources when choice is available.*	Case manager should offer a choice of referral sources for the client/family when choice is available. If choice is given the item should be marked "Yes." If choice is not given, the item should be marked "No." If no referrals are needed, the item should be marked "N/A."
b. Using support materials when giving information (i.e., referral forms, brochures, etc.). *	Case manager should provide referrals using the referral form or preprinted referral information that will give the client/family clear information on how to access referrals. If other information is given to dient/family, support materials such as brochures should be given. If appropriate support materials are not given the provider should receive a "No." If no information and/or referrals are needed, the item should be marked "N/A."
c. Demonstrating adequate knowledge of community resources.	Case manager should give appropriate community referrals to address client/family needs. If no information and/or referrals are provided, the item should be marked "N/A."
d. Following up appropriately on past referrals.*	Case manager should follow-up with the client/family on previous referrals given. If follow-up on past referrals is not done with every client the provider should receive a "No." If an initial visit with a client/family is observed, this item should be marked "N/A."
4. The observed contact included all requirements for a billable visit.*	Case manager included all requirements for either MCM or PWI billable contact. If all requirements are not included with every client, the provider should receive a "No."
5. Client/Guardian was allowed enough time to express needs and/or concerns.	Case manager should give the client/family enough time to express all needs/concerns.

REVIEW CRITERIA	Instructions
6. The observed contact was individualized to the client.*	Case manager should individualize the contact for each client seen. If services are not individualized for each client, the provider should receive a "No."
7. The case manager maintains confidentiality of client records during transport in accordance with agency policy.*	The observer should coordinate with the team leader to assure they have knowledge of the agency's policy regarding maintaining confidentiality of client records during transport. Case manager should follow the agency policy during observations. If the case manager does not follow the internal policy, the provider should receive a "No."
B. Client interviews	**Client interviews should be conducted after every observation. The team leader (or principle member for case management on a combined review) should also conduct 5 phone interviews with client/families picked randomly from the records being reviewed. * areas should receive a "No" if any client answers "No." All other areas the provider receives "Yes" on the site review tool if 80% of responses were positive on an item. The provider receives a "No" if less than 80% of responses were positive.** **Client interviews should be conducted privately. Ask the case manager to leave and wait outside for you.**
Case management services are provided according to policies and procedures as evidenced by positive answers in client interviews.	
1. The client understands what case management is.	Client/family indicated they do or do not understand what the case manager does and why they are receiving services.
2. The client was offered a choice of case management providers.* (when applicable)	Client/family indicated they were or were not given choice of case managers. If there is only one service provider in an area mark "NA". If choice was not offered to every client interviewed the provider should receive a "No."
3. Case management helped with needs client/family feels are important.	Client/family indicated they were or were not helped with needs that are important to them.

REVIEW CRITERIA	Instructions
4. Client/family was given referrals by the case manager that were helpful.	Client/family indicated they were or were not given referrals which were helpful.
5. Client was given choice of referral sources. (when applicable)	Client/family indicated they were or were not given choice of referral sources. If there is only one referral source in an area mark "NA"
6. Case manager helped client/family access needed medical and other services.	Client/family indicated they were or were not helped in accessing needed medical and/or other services.
7. Client/family feels more able to access medical and other services on their own using what they have learned from their case manager.	Client/family indicated they are or are not able to access medical and/or other services on their own using what they learned from their case manager.
8. Client/family stated case manager has been available when needed.	Client/family indicated the case manager has or has not been accessible to the client/family.
9. Client/family has not been billed for services.*	Client/family indicated they have or have not been billed for services by the provider. If any client was charged for services, the provider should receive a "No."
10. Client/family was offered the opportunity to have a home visit (if observation is done in office setting).	When observation is done in an office setting the client/family indicates they have or have not been offered a choice of a home visit.
11. Client/family is aware of process to file a complaint against case manager or case management provider.	Client/family indicated they are aware they can call 877-THSTEPS to file a complaint.

REVIEW CRITERIA	Instructions
II. Record Review	**All record review tools will be tallied for the site review tool. If the provider receives a "No" on any item marked with an *, the provider receives a "No" on the site review tool. All other areas the provider receives "Yes" on the site review tool if 80% of responses were positive on an item. The provider receives a "No" if less than 80% of responses were positive.** **Select records from the list submitted with the preplanning survey. Try to review 10% of records or a sample size large enough to identify problems. A minimum of 10 records should be reviewed. If the provider is both MCM and PWI review a minimum of 10 MCM records and 10 PWI records. 25% of the records reviewed should be closed records. (i.e. 20 records are reviewed, 5 of them should be closed records.)** **Document in this area the number of records reviewed for MCM and PWI by site. Include the number of open and closed records reviewed.**
A. Intake	**Record date of intake in shaded area on record review tool. If an intake is not included in a record and should have been, the provider should receive a – throughout the intake section on the record review tool.**
1. Intake is completed within 7 working days (2 working days if urgent) of referral.	Date completed is date signed by case manager. Compare date signed to date of referral. Are there more than 7 working days (2 if urgent) between these two dates?
2. Intake reflects client was offered choice of case management providers.	Is choice box marked or not?
3. Intake reflects client assessed for individual need for services.	Individual needs should be documented in "need for case management" box.
4. (MCM) Intake dated and signed by case manager using appropriate credentials.	Intake should be signed and dated by the case manager using the appropriate credentials (licensure). If the record is PWI, this item should be marked "N/A."

REVIEW CRITERIA	Instructions
5. (MCM) Intake reflects client appropriately meets eligibility criteria for health condition/health risk.	Intake reflects client is eligible for MCM. A client is eligible for MCM if he/she is determined to have a health condition or health risk that is above and beyond what is expected of healthy peers. If the record is PWI, this item should be marked "N/A."
6. (PWI) Intake reflects client was screened for high-risk condition.*	The high-risk condition or lack of a high-risk condition should be documented in the "health condition/high-risk" box. If the screen for high-risk condition isn't documented for a client, the provider should receive a "No." If the record is MCM, this item should be marked "N/A."
7. (PWI) Intake completed, dated and signed by case manager using appropriate credentials.*	Intake should be signed and dated by the case manager using the appropriate credentials (licensure). If the intake isn't signed and dated by the case manager, using appropriate credentials, the provider should receive a "No." If the record is MCM, this item should be marked "N/A."
B. Family Needs Assessment (FNA)	**Record date of FNA in shaded area on record review tool. If an FNA is not included in a record and should have been, the provider should receive a – throughout the FNA section on the record review tool. If an FNA is not documented in a record and not necessary for that record (for instance of a PWI client refuses services at the intake), "N/A" should be marked throughout the FNA section on the record review tool.**
1. FNA is completed within 7 working days (2 working days if urgent) of Intake.	Date of case manager signature is date of completion. Should be within 7 days of the date of case manager's dated signature on the intake (2 days if urgent).
2. (MCM) Comprehensive visit occurred in the home or explanation of why home visit did not occur is documented.	Is home marked on page one of the FNA? If not, is a reason a home visit not done documented? If the record is PWI, this item should be marked "N/A."
3. (PWI) FNA completed in a face-to-face contact.	Is face-to-face indicated on the FNA? If the record is MCM this item should be marked "N/A."
4. FNA supports client's eligibility for case management.*	Does documentation on the FNA indicate the client has a health condition/health risk above what would be expected of healthy peers (MCM) or a high-risk condition (PWI)? If any client is not eligible, this should be marked "No."
5. FNA is complete with all areas of assessment complete.	All FNA areas should be completed or the "No need" box should be checked.

REVIEW CRITERIA	Instructions
6. Needs identified at intake are appropriately reflected in the FNA.	Needs from the intake should be addressed or included on the FNA.
7. Documentation in FNA is individualized to the client.*	Documentation on the FNA must be individualized to the client. The needs of each eligible client should be reflected throughout the client record. If the needs are not individualized for each client, the provider should receive a "No."
8. Migrant Information Form is completed when required by policy.	If intake or FNA indicates the client/family is a migrant family, the migrant information form should be completed. If not a migrant family, "N/A" should be used.
9. FNA is dated and signed by case manager using appropriate credentials.*	FNA should be signed and dated by the case manager using the appropriate credentials (licensure). If the FNA isn't signed and dated by the case manager, using appropriate credentials for each client, the provider should receive a "No."
C. Service Plan (SP)	**Record date of service plan in shaded area on record review tool. If an SP is not included in a record and should have been, the provider should receive a – throughout the SP section on the record review tool. If an SP is not documented in a record and not necessary for that record (for instance of a PWI client refuses services at the intake), "N/A" should be marked throughout the SP section on the record review tool.**
1. SP Completed in a face-to-face contact.*	Face-to-face should be indicated on the SP. If face-to-face is not documented for each client, the provider should receive a "No."
2. (MCM) SP was completed at time of assessment or explanation of why completed separately is documented.	The MCM FNA, in conjunction with the SP comprises the billable comprehensive service. If the FNA and SP cannot be completed in one contact due to the complexity of the client/family situation, time constraints of the family and/or family preference, a second contact may be made to complete the comprehensive service. Appropriate documentation is required to explain the reason for non-completion in one visit. If the record is PWI, this item should be marked "N/A."
3. (PWI) The SP was completed within 7 days of the FNA.	If the PWI FNA and SP were not conducted in one contact, the SP must be conducted within 7 working days of the FNA. If the record is MCM this item should be marked "N/A."

REVIEW CRITERIA	Instructions
4. (PWI) The Intake and FNA or FNA and SP were conducted in one contact or there is a documented explanation why they were not.	TCM/PWI providers are encouraged to complete either the client intake and FNA or FNA and SP in one contact. If the contacts were not completed in this manner, there needs to be a documented explanation of why. If the record is MCM, this item should be marked "N/A."
5. SP includes interventions for all needs identified in FNA.*	All needs from the FNA should be addressed. If all needs are not addressed for each client, the provider should receive a "No."
6. SP includes specific action plans to meet needs identified in FNA.	The SP should include documentation of specific actions that clearly define how the needs from the FNA will be resolved.
7. SP includes responsibilities for case manager and client/family.	The SP should include documentation of the responsibilities of the case manager and client/family.
8. SP documentation includes specific time frames for accessing services.	The SP should contain specific time frames for accessing services. A month and year is appropriate. "Ongoing" as a time frame is not acceptable.
9. SP in English and client preferred language.	If the client/family prefers a language other than English the SP must be documented in both languages. If English is the client/family's preferred language, "N/A" should be used.
10. Copy of SP provided to client/parent/guardian in preferred language.	Documentation should indicate a copy of the SP was provided to the client/family on a specific date.
11. (MCM) Copy of SP forwarded to PCP or explanation documented why not to be forwarded.	A copy of the SP should be forwarded to the PCP (MCM) or there should be documentation that the client refused to have the SP forwarded. If the record is PWI, this item should be marked "N/A."
12. (MCM) Copy of SP forwarded to referral source or explanation documented why not forwarded**.**	A copy of the SP should be forwarded to the referral source (MCM) or there should be documentation that the client refused to have the SP forwarded. If the record is PWI, this item should be marked "N/A."
13. SP is signed and dated by Parent/Guardian/Client.*	The SP should be signed and dated by the parent/guardian/client on the day it was developed. If the SP isn't signed and dated by the parent/guardian/client for each client, the provider should receive a "No."

REVIEW CRITERIA	Instructions
14. SP is dated and signed by case manager using appropriate credentials.*	The SP should be signed and dated by the case manager using the appropriate credentials (licensure). If the SP isn't signed and dated by the case manager, using appropriate credentials for each client, the provider should receive a "No."
15. SP Addendum is completed when appropriate.	A SP addendum should be completed anytime new needs are identified. If no needs are identified, a SP Addendum isn't necessary and this item should be marked "N/A."
16. SP Addendum is signed and dated by client/parent/guardian.	The SP addendum should be signed and dated by the parent/guardian/client on the day it was developed. If no needs are identified, a SP Addendum isn't necessary and this item should be marked "N/A."
17. SP Addendum is dated and signed by case manager using appropriate credentials.	The SP addendum should be signed and dated by the case manager using the appropriate credentials (licensure). If no needs are identified, a SP Addendum isn't necessary and this item should be marked "N/A."
D. Follow-Up/Monitoring	**For record review tool, if all follow-ups for the record being reviewed meet criteria give a plus. If some of the dates meet criteria and others do not, give a +/-. When tools are tallied for the site review tool a +/- is counted as a -. If any one follow-up does not meet criteria for an item marked with *, the provider receives a "no" on the site review tool.** **If follow-up/monitoring contacts are not included in a record and should have been, the provider should receive a – throughout the follow-up/monitoring contacts section on the record review tool. If follow-up/monitoring contacts are not documented in a record and not necessary for that record (for instance, a client is lost to follow-up after the service plan), "N/A" should be marked throughout the follow-up/monitoring section on the record review tool.**
1. Follow-up/monitoring documentation indicates if contact occurred face-to-face or over the telephone.	The face-to-face or telephone box should be marked.
2. Client Follow-Up/Monitoring contacts occurred according to plans on SP and Follow-Up/Monitoring forms or documentation explains why.	Follow-Up/Monitoring contacts should occur according to the schedule designated on the SP or previous Follow-Up/Monitoring contacts. If the contact was not done according to the schedule, the documentation should indicate why.

REVIEW CRITERIA	Instructions
3. Follow-up/monitoring documentation continues to support eligibility for case management services.*	Follow-Up/Monitoring contacts should still continue to document the client has a health condition/health risk (MCM) or a high-risk condition (PWI) and that the client still has needs and the client/family desires services. If any client is not eligible for services during a Follow-Up/Monitoring contact, the provider should receive a "No."
4. Follow-up/monitoring documentation reflects entire service plan was reviewed with client/parent/guardian.*	All outstanding needs on the SP should be reviewed with client/parent/guardian during each follow-up/monitoring visit. The case manager may document this review for needs which have no new activity by checking the service plan reviewed and updated with client/parent/guardian box on the Follow-Up/Monitoring form. The case manager must document activity on at least one need on the SP to justify the need for the follow-up/monitoring contact. If a follow-up does not indicate the entire service plan was reviewed, mark "-" on the record review tool.
5. Client Follow-Up/Monitoring visits occurred as appropriate to client needs.	Follow-Up/Monitoring contacts should occur according to the client needs.
6. Follow-Up/Monitoring documentation includes advocacy and empowerment.	Follow-Up/Monitoring contacts should include documentation of advocacy and empowerment.
7. Follow-Up/Monitoring documentation reflects appropriate referrals.	Follow-Up/Monitoring contacts should include referrals appropriate to the client/family needs.
8. Documentation indicates the follow-up/monitoring visit is individualized to client's needs.	Documentation on the Follow-Up/Monitoring contacts must be individualized to the client. The needs of each eligible client should be reflected throughout the client record.
9. Documentation includes timeframe for next follow-up/monitoring visit or indicates case will be closed.	All Follow-Up/Monitoring contacts should include documentation of a time frame for the next Follow-Up/Monitoring contact. The plan for the next Follow-Up/Monitoring contact should not state "PRN" or "as needed." The follow-up plan should be individualized to the client need, for example, "within two days," "within two weeks," or "within two months."

REVIEW CRITERIA	Instructions
10. Follow-up/monitoring visit form is dated and signed by case manager using appropriate credentials.*	Follow-up/Monitoring contacts should be signed and dated by the case manager using the appropriate credentials (licensure). If a Follow-up/Monitoring contact isn't signed and dated by the case manager, using appropriate credentials in every record, the provider should receive a "No."
E. Closure	
1. Closure Form is completed with all areas addressed.	The closure form should be completed when a case is closed. If a case is still open, the record review tool should be marked "N/A."
2. Closure Form is signed by parent or explanation documented why not signed.	A client/parent/guardian must sign the closure form as agreement with decision to close/transfer the case. If the client/parent/guardian is not available/refuses to sign the form, the case manager must document the reason it is not signed. If a case is still open, the record review tool should be marked "N/A."
3. Documentation reflects all client needs have been addressed or attempted to address before closure.	The documentation should indicate all needs have been met or attempted to have been met before closing the case. If a case is still open, the record review tool should be marked "N/A."
4. Documentation reflects transition to alternative case manager when appropriate.	The referral form must include documentation that the client was appropriately transitioned to another provider (when applicable). If a case is still open, the record review tool should be marked "N/A."
5. Documentation reflects necessary referrals were provided.	The referral form must include documentation that appropriate referrals to resources have been made. If a case is still open, the record review tool should be marked "N/A."
6. (MCM) Closure Form forwarded to PCP or explanation documented why not forwarded.	A copy of the closure form should be forwarded to the PCP (MCM) or there should be documentation that the client refused to have the closure form forwarded. If a case is still open the record review tool should be marked "N/A." If the record is PWI, this item should be marked "N/A."
7. Closure Form signed and dated by case manager**.**	A qualified case manager must sign the closure form as agreement with decision to close/transfer the case. If a case is still open, the record review tool should be marked "N/A."

REVIEW CRITERIA	Instructions
F. Other	
1. All referrals are documented according to policy including client choice.	A standard referral form (form CPW-07) provided by TDH may be used by CM providers. Case management providers may choose to use pre-printed referral information or a substitute form as long as these documents include all the components from the referral form CPW-07 and documentation of client choice is included in the client record. A copy of the list should be placed in the client record. When only one referral resource is provided to client, documentation on Follow-Up form or progress note must provide explanation for limited referral choice.
2. Release(s) of information is/are documented as required in policy.	If information is to be released to a third party, who is not included in the SP, a separate release must be obtained. If a release is not necessary, the record review tool should be marked "N/A."
3. Documentation reflects compliance with ADA, LEP and civil rights requirements.	The Americans with Disabilities Act (ADA) requires that interpreters be provided and the cost not be transferred to the client. Providers are expected to make all reasonable accommodations. All written communication with clients/families must be delivered in a culturally and educationally sensitive manner. All written materials meant for distribution to clients/families must be provided in a format that is sensitive to language, culture and educational differences. Any record documentation provided to a family and requiring parent signature, must be interpreted/translated for the family. Any record documentation written in the client's preferred language must also be documented in English on either the same form or a new form. If none of these areas apply to a client/family, the record review tool should be marked "N/A."

REVIEW CRITERIA	Instructions
4. Documentation reflects an evaluation for potential abuse has been made according to the agency/provider's policy and procedure for how it will determine, document and report abuse, sexual or non-sexual in accordance with Texas Family Code, Chapter 261.*	All reports of suspected child abuse should be documented in the client's record. Insure that documentation reflects that the contractor has determined, documented, and reported abuse according to the TDH Child Abuse Screening, Documenting, and Reporting Policy and the contractor's internal policy for determining, documenting and reporting instances of abuse. If the reviewer determines that a report was not documented when one should have been made, the reviewer will direct the contractor make a report before the end of the business day. When reviewing records of clients ages 14 through the end of the 16th year who are pregnant or have a confirmed STD, make certain the case manager has documented the age of the client's sexual partner and reported as appropriate per the Rider 14 section of the case management child abuse policy. Although case management providers are not required to use the Checklist for TDH Monitoring for documentation for clients ages 14 through the end of the 16th year, the provider can use the form if so desired. If a record does not contain documentation of a report of suspicion of child abuse (when applicable) the provider should receive a "No." If there is no need for report of abuse mark "NA."
5. (MCM) Request for Prior Authorization is completed when appropriate.	If a client/family requires additional THSteps MCM visits, the services must be authorized prior to service delivery. If prior authorization is not necessary, the record review should be marked "N/A." If the record is PWI, this item should be marked "N/A."
6. Evidence of coordination with community-based agencies when appropriate.	Case managers should document coordination with community-based agencies for the purpose of implementing service plans. If no coordination was needed, the record review tool should be marked "N/A."
7. Evidence of coordination with managed care is documented when appropriate.	For case management clients covered by a Medicaid Managed Care Plan, Case Management providers will, at a minimum, place a call or send an e-mail notifying the plan that the client is receiving case management services from the provider. Documentation confirming that the call or e-mail was completed should be noted in progress notes or indicated in the Service Plan. Required effective 6/102, if the client is not enrolled in Medicaid Managed Care, the record review tool should be marked "N/A."

REVIEW CRITERIA	Instructions
8. Need for change in case managers is documented, when applicable.	If the client's case manager has changed, the change and reason for the change should be documented. If the case manager hasn't changed, the record review tool should be marked "N/A."
9. Forms being utilized are the appropriate revision date.	The current forms should be used for all documentation.
10. Appropriate consent for services obtained if client under 18 and not emancipated or over 18 with court appointed guardian.	If services are provided to client without parent/guardian, a consent signed by the parent/guardian for services must be in the client's record for all clients under 18 and not emancipated or over 18 with a court appointed guardian. If services provided with a parent/guardian or if a client is over 18 and has no court appointed guardian, the record review tool should be marked "N/A."
G. Comparison of Client Records/Billing	**All records reviewed must be compared with the provider's billing in the Phoenix system and document on the billing review tool. In addition, 5 other records will be selected and reviewed for billing only.**
1. The dates of contact(s) in the documentation match the date(s) of service billed.*	The dates of contact in the client record should match the date of service billed. If a date of service does not match the client record, the provider should receive a "No."
2. The contact(s) were billed appropriately as face-to-face or telephone.*	The contacts reviewed should have been billed appropriately as face-to-face or telephone. If a service was not billed appropriately as face-to-face or telephone, the provider should receive a "No."